COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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To: State Retiree Health Benefits Program Participants Not Eligible for Medicare

From: Mary P. Habel, Director
State and Local Health Benefits Programs

Date: April 9, 2004

Re:
- Your Monthly Premium Rates and Plan Choices Effective July 1, 2004
- Open Enrollment
- Important Retiree Group News and Updates

Recipients of this Package Retiree group participants receiving this package include Retirees, Survivors, Virginia Sickness and Disability Program Long Term Disability (LTD) Participants and some eligible dependents who are covered separately from their spouse or parent.

What's New for July 1, 2004

- *Open Enrollment* -- From April 14 to May 14, 2004 is your opportunity to review your current health plan coverage and make changes based on your needs for the new plan year that is effective on July 1, 2004. See more about Open Enrollment beginning on page 3.
- *Plan Year* – The COVA Care plan benefit year changes from the calendar to the fiscal year (July 1 – June 30). See page 2.
- *Plan Administrators* – Although coverage will remain the same, COVA Care will have four separate administrators of benefits. See page 2.
- *New Premium Rates* -- Following are monthly premium costs that will become effective on July 1, 2004:

Plan	*Single Premium*	***Two-Person Premium***	***Family Premium***
COVA Care Basic	**$334**	**$619**	**$903**
COVA Care + Out-of-Network	**$342**	**$630**	**$917**
COVA Care + Expanded Dental	**$344**	**$638**	**$933**
COVA Care + Vision, Hearing and Expanded Dental	**$351**	**$651**	**$949**
COVA Care + Out-of-Network and Expanded Dental	**$352**	**$649**	**$947**
COVA Care + Out-of-Network and Vision, Hearing and Expanded Dental	**$359**	**$662**	**$963**
Kaiser Permanente HMO	**$337**	**$623**	**$910**

Available Plans

- *COVA Care Plan* -- There will be no changes to COVA Care plan covered services, deductibles, copayments or coinsurance on July 1. However, there are changes in administration of some benefits under COVA Care. ***Please read all materials carefully. Be sure that you are using the correct provider network and that you direct questions (starting now) and claims (starting July 1) to the appropriate administrator.*** See more about COVA Care below.
- *Kaiser Permanente HMO* – **This plan is available only to participants who live in the Kaiser service area in Northern Virginia.** If you live in Northern Virginia and are interested in Kaiser coverage, contact Kaiser directly. If you are a current Kaiser member and do not live in its service area, you must either elect the COVA Care statewide plan or cancel coverage in the Retiree Health Benefits Program. Contact Kaiser directly or visit its Web site to determine if your home address is in the Kaiser service area. See the Plan Contact Summary on page 8.

COVA Care Benefit Plan Year Beginning July 1, COVA Care's benefit year will change from January 1—December 31 to **July 1—June 30**. To help you with this transition, any portion of your medical and/or behavioral health deductible or out-of-pocket limit that you have met by June 30 will not have to be satisfied again once the new benefit year begins on July 1. This expands by six months the amount of time you have to meet your deductible or out-of-pocket limit.

- Plan maximums for medical services such as routine wellness and chiropractic care will start over with the new benefit year effective July 1.
- Dental care maximums ($1200 under COVA Care, and $1500 under COVA Care with Expanded Dental) will start over again on July 1. The $1200 orthodontic lifetime maximum under the Expanded Dental option will not start again on July 1.
- Those participants with routine vision coverage will still be limited to benefits once every 24 months.

COVA Care Plan Administrators Effective July 1, four administrators will administer your COVA Care benefits. See page 8 for a list of administrators and contact information.

- You will have ***four separate identification cards*** to use for the appropriate COVA Care benefit. Present your new cards to your provider (your doctor, dentist, mental health professional or pharmacist) for services beginning July 1.
- ***Using a provider who participates in the new administrators' networks is important to your coverage under COVA Care:***
  - Except for those with a behavioral health transition benefit (see page 3), COVA Care members who use providers outside the networks after June 30 for medical or behavioral health benefits will have no coverage unless they have elected the out-of-network benefit option; and
  - Using a non-participating provider for dental, vision, hearing or prescription drug benefits may result in higher out-of-pocket expenses. You may need to file the claim yourself.

An article in your enclosed ***Open Forum*** newsletter will introduce you to your new administrators (including access to their provider networks) and new ID card formats.

COVA Care Behavioral Health Transition Period COVA Care participants who are in outpatient behavioral health treatment prior to July 1, 2004 will have a transition period of up to three months (July 1 through September 30, 2004) or 10 visits, whichever comes first.

- This will allow continued coverage for services from a provider who does not participate with ValueOptions, the new administrator for behavioral health benefits. However, be sure to contact ValueOptions as soon as possible to identify a provider who participates in the ValueOptions network.
- If you continue to receive treatment from a non-ValueOptions network provider during the transition period, you will be responsible for any amount over the allowable charge.
- ***After you have exhausted the transition benefit, you will have no coverage if you use a non-ValueOptions provider*** (unless you have purchased the out-of-network optional benefit).

If you have the Out-of-Network option, you may use any provider after the transition benefit has been exhausted, as long as the services are covered and medically necessary. However, your benefit will be reduced by 25% of the allowable charge, and you may experience balance billing since non-participating providers are not restricted to the plan's allowable charge.

Did you know that the Employee Assistance Program (EAP) is available to COVA Care participants in the retiree group? Consult your Member Handbook to see what types of services are available, or, starting July 1, contact ValueOptions at 1-866-725-0602. Kaiser Permanente HMO participants also have EAP benefits. More information on Kaiser EAP benefits may be obtained directly from Kaiser at (703) 873-1503.

COVA Care ID Cards You will receive ***four new ID cards*** for use starting July 1. Be sure to present the appropriate card to your medical (including vision and hearing, if you have chosen that option), dental, behavioral health and prescription drug providers. See the enclosed ***Open Forum*** newsletter for samples of your new card formats and for more information about your new administrators.

COVA Care Member Handbooks All COVA Care retiree group enrollees will receive a new Member Handbook along with their Anthem ID card. This Member Handbook describes all COVA Care benefits, even those administered by Delta Dental, ValueOptions and Medco Health. Even though you will receive four different ID cards, you will receive only one Member Handbook, and it will come to you from Anthem prior to July 1.

Open Enrollment During Open Enrollment, you may:

- Review and make changes to your health plan;
- Add or remove dependents, making any appropriate change to your health plan membership;
- Add or remove a COVA Care optional benefit.

For more information about COVA Care optional benefits, see your COVA Care Member Handbook. If you do not have a member handbook, please contact Anthem for more information—see page 8.

To maintain your current plan and membership level, take no action. Your new monthly premium will automatically be deducted or billed in the usual way. If your retirement annuity is insufficient to cover the amount of your new monthly premium, direct billing will begin automatically in June for your July premium.

Enroll online! Use EmployeeDirect on the Web at http://edirect.virginia.gov. Step-by-step instructions are on the "Welcome" page. If you choose not to use EmployeeDirect during the Open Enrollment period, be sure that your Benefits Administrator receives your completed enrollment form no later than May 14, 2004 (see below for more about completing the form). After Open Enrollment, you may make plan or membership changes **only** if a consistent qualifying mid-year event occurs (such as marriage, birth of a child, etc.).

Completing an Enrollment Form - To make an Open Enrollment change by using the enclosed enrollment form, please complete the following:

Part A
- Complete the ***Enrollee Information***
- Check the ***Open Enrollment*** box
- Select the correct ***Type of Membership*** for your new election (be sure to include both new and existing participants)

Part B
- ***List all eligible participants whom you wish to enroll***—include yourself and all dependents, both new and existing

Part C
- This section only applies during Open Enrollment if you have a participant who becomes newly eligible for Medicare

Part D
- Indicate the selected plan for you and your covered family members

Part E
- Read the ***Enrollee Statement*** and the ***Certification/Authorization*** and have the form signed by the Enrollee (not a dependent)

Part F
- This section does not apply to Open Enrollment activities

Once your form is completed, send it to the appropriate Benefits Administrator listed on the first page of the form. For Virginia Retirement System (VRS) retirees or survivors, or for VSDP/Long Term Disability participants, this will be VRS. However, Optional Retirement Plan or Local Retirees or Survivors should send their form to their pre-retirement agency's Benefits Administrator.

All enrollment forms must be signed by the eligible Enrollee -- the retiree, survivor or VSDP/LTD participant through whom dependents are covered. Enrollment forms for eligible dependents, even those who have separate or individual coverage, must be signed by the Enrollee. *Unless it is properly signed by the Enrollee, your enrollment form will not be accepted.*

Medicare-Eligible Participants Under Age 65 When an Enrollee (retiree, survivor, VSDP/LTD participant) or a covered dependent becomes eligible for Medicare prior to age 65, an enrollment form must be submitted immediately to elect a Medicare-coordinating plan. It is the responsibility of the Enrollee to ensure that this is done. Failure to submit a form could cause a significant gap in your coverage.

This is an important provision of the State Retiree Health Benefits Program. All participants who are eligible for Medicare, regardless of age, must enroll in both Parts A and B in order to get the full benefit of any state Medicare supplemental coverage since Medicare becomes the primary payer of claims. If it is determined that a retiree group participant is eligible for Medicare and has not enrolled in a Medicare-coordinating plan, he or she will be placed in the Advantage 65 plan immediately.

Starting in January 2005, the State Retiree Health Benefits Program will actively seek retraction of primary payments made in error on behalf of participants who are entitled to Medicare benefits but who have not reported that eligibility to their Benefits Administrator. If participants have declined their Medicare Part B coverage, it could result in a delay in Part B enrollment and, as a result, a critical gap in coverage until Part B goes into effect. Please do not overlook your responsibility to report your Medicare eligibility and to enroll in Advantage 65 immediately. If you fail to enroll in Medicare Parts A and B immediately upon your eligibility to do so, the Program will pay claims on a secondary basis as though you had the Medicare coverage to which you were entitled.

Becoming Eligible for Medicare During Open Enrollment Approximately three months before their 65th birthday, all retiree group participants, including covered dependents, receive information about options for selecting a Medicare-coordinating plan. At that time, if an election is not made, Medicare-eligible members are placed in the Advantage 65 Plan. This process continues during the Open Enrollment period, so some members will receive both a Medicare plan enrollment package and an Open Enrollment package. If you become eligible for Medicare prior to July 1, your Medicare plan election will replace any Open Enrollment election. If you become eligible for Medicare after July, you may make an Open Enrollment election for July 1, and your Medicare plan election will take place on the first of the appropriate month after July.

Prompt Payment of Premiums Plan participants are responsible for paying monthly premiums on time (either through annuity deduction or by direct payment to the carrier).

- Participants who pay directly to the carrier (Anthem or Kaiser) receive monthly bills or coupons which indicate when premium payments are due.
- If monthly premiums remain unpaid for 31 days after the due date, **coverage will be terminated**.
- Starting in January 2005, claims during any period for which premium payment in full has not been made will be denied until payment has been received. This includes prescription drug benefits. Resubmission of any denied claims may be required.
- Once an Enrollee and his/her dependents have been terminated for non-payment of premiums, re-enrollment in the program is not allowed except in extreme circumstances and at the discretion of the Department of Human Resource Management.

It is your responsibility to understand your premium obligation and to notify the program within 31 days of any qualifying mid-year event that affects eligibility and/or membership level. If you fail to report a membership reduction, you may forfeit any premium overpayments you made.

Direct Billing of Premiums For some retirees, an increased premium will mean that the amount of your monthly retirement annuity will no longer be sufficient to cover your monthly premium amount. In those cases, you will begin to be billed directly by Anthem (or Kaiser Permanente, if appropriate). Keep in mind that, due to administrative differences, direct billing occurs in advance of the coverage month, while annuity-deducted premiums are collected in arrears.

Automatic Bank Draft of Premiums Starting in January 2005, retiree group participants who are billed directly by Anthem will have the opportunity to have their premiums automatically deducted from their bank account. For many participants, this will be a welcome relief from submitting a monthly premium payment. You will receive additional information and enrollment materials before the end of the year.

Eligibility of Dependent Children In the 2003 Open Enrollment package for non-Medicare retiree group participants, information about a change in the eligibility rules for dependents raised some questions from participants. Here is the complete definition of **children eligible for coverage under the State Retiree Health Benefits Program**:

- The retiree's unmarried biological or legally adopted children through the end of the year in which they reach age 23* as long as they live at home and are eligible to be claimed on the parent's federal income tax return, or children placed in the home under a pre-adoptive agreement which has been approved by the Department of Human Resource Management. Children will be considered as living at home if they live with the other parent (if the employee is divorced or separated) or if the child lives away from home while attending college or boarding school.
- Unmarried stepchildren living full time with the retiree in a parent-child relationship and who are claimed on the retiree's federal tax return.
- Adult children with disabilities who are approved per plan provisions.
- Other children may be covered based on permanent legal custody ordered by a court and given to a retiree and/or spouse, as approved by the Department of Human Resource Management.

*Different eligibility rules exist for non-annuitant survivors. If your child is covered as a non-annuitant survivor, please consult your Benefits Administrator if you need additional information.

If you have additional questions, contact your Benefits Administrator. The Virginia Retirement System (VRS) acts as Benefits Administrator for their retirees, survivors and VSDP/LTD participants. Other retirees (e.g., Optional Retirement Plan or Local Retirees and their dependents) should contact their pre-retirement agency's Benefits Administrator for assistance.

Resources for Retiree Group Enrollees Please refer to the Plan Contact Summary on page 8 to identify your resources when you have questions regarding your State Retiree Health Benefits Program coverage.

Address Changes Was this package forwarded to you from an old address? If so, be sure to contact your Benefits Administrator immediately to make an address correction. You may miss important information about your health benefits if you fail to update your address. The Department of Human Resource Management will not be responsible for information that participants miss because their address of record is incorrect. The Department's only means of communicating important information to retiree group participants is through the mail. Please let your Benefits Administrator know when you move! You may also change your address by using EmployeeDirect at http://edirect.virginia.gov.

Note to Long Term Disability (LTD) Participants Effective July 1, 2004, there will be a change for those eligible LTD participants who "waive" (not cancel) coverage at the start of LTD or due to a consistent qualifying mid-year event (and who maintain their waive status). Currently, they can return to the State Retiree Health Benefits Program prospectively at any time, but only in single coverage. Effective July 1, 2004, eligible LTD participants in waive status will only be allowed to return to the program if a consistent qualifying mid-year event occurs or at Open Enrollment (non-Medicare participants only). Please keep this new plan provision in mind if you choose to waive your coverage prior to July 1, 2004.

Enclosures:

- Enrollment Form
- ***Open Forum*** Newsletter
- Plan Contact Summary (attached)
- Women's Health and Cancer Rights Information (attached)

Plan Contact Summary

If you have a question regarding benefits or claims, or to check on a participating provider:

Benefit	***Contact This Administrator***
• Medical • Optional Vision or Hearing	Anthem Blue Cross and Blue Shield 1-804-355-8506 (in Richmond) 1-800-552-2682 (outside of Richmond) Web site: www.anthem.com
• Behavioral Health or Employee Assistance Program	Value Options, Inc. 1-866-725-0602 Web site: www.achievesolutions.net/covacare
• Dental	Delta Dental Plan of Virginia 1-888-335-8296 Web site: www.deltadentalva.com
• Prescription Drugs	Medco Health Solutions, Inc. 1-800-355-8279 Web site: www.medcohealth.com
• Kaiser Permanente HMO	1-301-468-6000 or 1-800-777-7902 Web site: http://my.kaiserpermanente.org/mida/commonwealthofvirginia/

If you have questions on eligibility:

If you are a:	***Contact This Benefits Administrator***
Virginia Retirement System Retiree/Survivor or a Long Term Disability Program Participant	The Virginia Retirement System 804/649-8059 (in Richmond) 1-888-827-3847 www.varetire.org
Local or Optional Retirement Plan Retiree or Survivor	Your Pre-Retirement Agency Benefits Administrator

The Department of Human Resource Management Web site also has information about the State Retiree Health Benefits Program. Go to www.dhrm.virginia.gov.

Notice

<u>Women's Health and Cancer Rights</u>

In the case of a participant who is receiving benefits under the state's health benefits plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- **Reconstruction of the breast on which the mastectomy has been performed**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance**
- **Prostheses and physical complications during all stages of the mastectomy**